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SUBMISSION OF THE ADVOCACY CENTRE FOR THE ELDERLY TO THE STANDING COMMITTEE ON GENERAL GOVERNMENT

November 25, 2015

The Advocacy Centre for the Elderly ("ACE") is pleased to provide comment on Bill 122, *Mental Health Statute Law Amendment Act, 2015* ("Bill 122"), based upon our extensive experience advocating for older adults in Ontario and our expertise in the area of mental health law.

After providing a brief introduction to ACE, we will examine the following issues raised by Bill 122 as they affect older adults:

1. "Informal" or "voluntary "patients are excluded from the changes envisioned by the amendments;
2. Treatment should not be ordered without consent and transfers should not be ordered by the Consent and Capacity Board ("CCB") over the patient's objection; and,
3. The composition of the CCB should better reflect the patient population and ensure expertise to address the expanded powers granted to the CCB by the amendments.

We thank you for the opportunity to provide our submissions in this regard. ACE would be happy to participate in any further consultations or discussions with the Committee if required.

INTRODUCTION TO ACE

The Advocacy Centre for the Elderly is a specialty community legal clinic, funded by Legal Aid Ontario, which was established to provide a range of legal services to low income older adults in Ontario. The legal services include individual and group client advice and representation, public legal education, community development, and law reform activities. ACE has been operating since 1984 in Toronto, and is the first and oldest legal clinic in Canada with expertise in legal issues of the older population.

On average, ACE receives over 3,000 client intake inquiries a year. Most of the telephone inquiries come from the Greater Toronto Area with approximately 20% originating from other areas of the province. From time to time, ACE also receives inquiries from outside of Ontario. The individual client services are in areas of law that have a particular impact on older adults. These include, but are not limited to: capacity, substitute decision-making and health care consent; end-of-life care; supportive housing and retirement home tenancies; long-term care homes; patients' rights in hospitals; and elder abuse. Clients regularly seek our advice on issues relating to mental health issues.

ACE has also been involved in several high profile inquests. In 2005, ACE represented Concerned Friends of Citizens in Ontario Care Facilities at the Ez-El-Dine El-Roubi and Pedro Lopez inquest (commonly known as the "Casa Verde Inquest"). Forty-three witnesses gave evidence during the 34 day long inquest. The coroner's jury made 85 recommendations with regards to housing options for complex and behaviourally difficult older adults.

As part of its law reform mandate, ACE staff have been involved in many of the law, policy, and education initiatives related to health care consent and mental health that have taken place in Ontario over the last 30 years. These have included:

- participating as a member of the Fram Committee, the work of which resulted in the passage of the *Consent to Treatment Act, 1992* and subsequently the *Health Care Consent Act, 1996*;[1]
- acting as one of the principal writers of the training materials for health professionals that were produced as part of two of the Alzheimer Society of Ontario Initiatives (# 2 and #7) on Physicians' Education and Advance Directives on Care Choices;
- participating currently on the Advisory Committee for the Law Commission of Ontario Project on Legal Capacity, Decision-making and Guardianship;
- making submissions to the Mental Health Commission of Canada and the Select Committee for Mental Health and Addictions;
- making submissions to the Ontario Human Rights Commission on its Mental Health Strategy; and,
- co-authoring (with the law firm of Dykeman Dewhirst O'Brien LLP) a major research paper on health care consent and advance care planning for the Law Commission of Ontario.[2]

SUBMISSIONS OF THE MENTAL HEALTH LEGAL COMMITTEE

We have reviewed the draft submissions of the Mental Health Legal Committee ("MHLC"), an association of lawyers and community legal workers of which ACE is a part. We fully support the submissions of the MHLC including the call for an expansion of the scope of the CCB's proposed review powers, such as supervision of the issuance of community treatment orders, the ability to order a discharge with supports, and the ability to review the conditions of the hospital stay of long-term voluntary patients. We also support a reduction of the restrictions on the timing, frequency, and access to these

[1] *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sched. A (*HCCA*)
[2] Judith Wahl, Mary Jane Dykeman and Brendan Gray, *Health Care Consent and Advance Care Planning in Ontario: Legal Capacity, Decision-Making in Guardianship,* Law Commission of Ontario: January 2014, available at: http://www.lco-cdo.org/capacity-guardianship-commissioned-paper-ace-ddo.pdf

powers and further clarification on the authority to order an independent assessment, as detailed in the proposed amendments.

Our submission will focus on the amendments as they affect older adults.

BILL 122 AS IT AFFECTS OLDER ADULTS

Bill 122 was introduced as a response to a recent case decided by the Court of Appeal. In *P.S. v. Ontario*, the Court found that the detention provisions in the *Mental Health Act ("MHA")* did not contain adequate procedural protection for the liberty interests of long-term psychiatric patients, such that it violated section 7 of the *Canadian Charter of Rights and Freedoms ("*the Charter").[3] Bill 122 seeks to amend the *MHA* to expand the review of long-term involuntary detention by providing powers to the CCB to make an order on application or of its own motion to:

1. Transfer the patient to another psychiatric facility if the patient does not object, subject to subsections 41.1 (10), (11) and (12).
2. Place the patient on a leave of absence for a designated period on the advice of a physician, subject to subsection 41.1 (13).
3. Direct the officer in charge of the psychiatric facility to provide the patient with a different security level or different privileges within or outside the psychiatric facility.
4. Direct the officer in charge of the psychiatric facility to allow the patient to be provided with supervised or unsupervised access to the community.
5. Direct the officer in charge of the psychiatric facility to provide the patient with vocational, interpretation or rehabilitative services.[4]

These powers are only accessible on confirmation of a certificate of continuation. This means that a patient in a psychiatric facility will only be able to seek these orders if the following criteria are met:

[3] *P.S. v. Ontario,* 2014 ONCA 900 (CanLII)
[4] Bill 122, *Mental Health Statute Law Amendment Act, 2015,* s. 41.1(2)

1. **The patient is involuntarily admitted**: This is either by use of a certificate of involuntary admission or a certificate or renewal. These certificates can only be completed where an attending physician completes a certificate of involuntary admission on grounds that are colloquially known as Box A or Box B:

   Box A grounds: the physician is of the opinion that the patient is "suffering from mental disorder of a nature or quality that likely will result in serious bodily harm to the patient, serious bodily harm to another person, or serious physical impairment of the patient, unless the patient remains in the custody of a psychiatric facility; and that the patient is not suitable for admission or continuation as an informal or voluntary patient".[5]

   Box B grounds: Box B sets out two additional grounds of committal not contained in Box A: that of substantial mental deterioration or substantial physical deterioration. However, in order to rely on these grounds, the physician must be of the opinion that the patient:

   (a) has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in serious bodily harm to the person or to another person or substantial mental or physical deterioration of the person or serious physical impairment of the person;
   (b) has shown clinical improvement as a result of the treatment;
   (c) is suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;
   (d) given the person's history of mental disorder and current mental or physical condition, is likely to cause serious bodily harm to himself or herself or to another person or is likely to suffer substantial mental or physical deterioration or serious physical impairment;

[5] *Mental Health Act,* R.S.O. 1990, c. M.7, s. 20(5)

(e) has been found incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained; and

(f) is not suitable for admission or continuation as an informal or voluntary patient.[6]

The initial certificate of involuntary admission may only detain the patient for up to two weeks, with the first certificate of renewal being for a period of one month, the second for two months, and the third for three months. Certificates must be consecutive with no lapses in between; otherwise, the process starts anew.

2. **The patient is detained for 6 months and two weeks:** The certificate of continuation will only be completed by a physician after the patient has been detained under a certificate of involuntary admission and three certificates of renewal.[7]

ACE welcomes these improvements to review the conditions of detention of long-term psychiatric patients, however, feels that additional amendments would be needed to address the needs of older adults.

1. *Informal or Voluntary Patients*

ACE wishes to draw attention to the fact that the proposed regime for CCB review of detention does not, and will not, apply to informal or voluntary patients. These patients are not "certified" under the *MHA*: that is, they are not held under certificates of involuntary admission or renewal. Nevertheless, they may be held in psychiatric facilities for extended periods of time, making these patients extremely vulnerable and their stay equally deserving of review.

The *MHA* defines "informal patient" as a person who is a patient in a psychiatric facility, having been admitted with the consent of another person under section 24 of the *Health*

[6] *Ibid.,* s. 20(1.1)
[7] Bill 122, *supra,* note 4, s. 4(1)

Care Consent Act, *1996 ("HCCA")*.[8] Section 24 of the *HCCA* provides that a substitute decision-maker ("SDM") who consents to treatment on an incapable person's behalf may consent to the person's admission to a psychiatric facility.[9] However, where the patient objects to the admission, only two of the SDMs in the hierarchy have authority to override these objections. These overrides are limited to: (1) court-appointed guardians of the person, where the court has granted them authority for admission, or (2) attorneys authorized under powers of attorney for personal care which specifically allow them to use necessary and reasonable force to admit an incapable person to a psychiatric facility (referred to as "Ulysses agreements").[10]

However, as with many areas of the law when older adults are involved, the law is not consistently applied. ACE has received many calls from patients whose SDMs have consented to their admission to psychiatric facilities or other hospitals without meeting the requirements under section 24 of the *HCCA.* In other cases, despite the fact that the older adult objects to remaining in the psychiatric facility, they are simply detained without being made involuntary and therefore have no access to a right of review. ACE's experience is that where it comes to geriatric patients, detention in a psychiatric facility suffers from the problem of "good law, bad practice".

With respect to admission on consent of a SDM, the confusion may lie in the fact that there is a hierarchy of SDMs who can consent to treatment; however, only a few of those can consent to admission to a psychiatric facility over the objection of the patient. The hierarchy of SDMs that can consent to treatment where a patient is incapable of doing so on his/her own behalf is as follows:

1. guardian of the person appointed by the court.
2. attorney for personal care.
3. a representative appointed by the CCB.
4. spouse/partner.
5. child or parent.
6. parent with only a right of access;

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[8] *MHA, supra,* note 5, s. 1.1 "Informal patient"
[9] *HCCA*, *supra*, note 1, s. 24(1)
[10] *Ibid.*, s. 24(2)

7. brother or sister.
8. any other relative.[11]

Of these possible SDMs, only guardians of the person and attorneys for personal care can authorize admission and detention in a psychiatric facility, and even then, only in very limited circumstances. As the hospital is used to obtaining consent to treatment from the family of the patient as SDMs, the staff may accept consent to admission from these SDMs as well.

In the alternative, patients may simply be admitted and detained despite their objections, because of a misplaced attitude of acting in the elderly person's "best interest". It has been ACE's experience that older patients suffering from dementia are perceived as somehow "different" than younger patients suffering from a major psychiatric illness, such as schizophrenia or bipolar disorder, leading to the erosion or ignoring of their legal rights.

While these patients are not technically involuntarily detained under the *MHA,* they are, as a matter of course, admitted and kept in hospital by their attorneys for personal care, guardians, or by hospital staff. The psychiatric facilities may not look to the power of attorney or guardianship order to determine whether the order or power of attorney provides for detention, or may believe that they have the right to detain the patient without due process

Moreover, the lack of housing options for older adults with serious dementia, which results in difficult-to-manage behaviours, places pressure on SDMs and hospitals to admit incapable patients into psychiatric facilities, at times, without a view to the incapable person's legal rights.

These highly vulnerable informal patients may be in hospital against their will but they have no mechanism to challenge the conditions of their stay in hospital. If the involuntary detention provisions in the *MHA* could not pass constitutional scrutiny in *P.S. v. Ontario*,

[11] *Ibid.,* s. 20(1)

the situation of patients who have no access to procedures to review their detention at all, as outlined above, would surely fall afoul of section 7 of the *Charter*.

Similarly, voluntary patients, as discussed in the MHLC's submissions, have no access to the regime proposed by Bill 122. A voluntary patient is not defined in the *MHA,* but the Court has provided that "… the person must be in a position to exercise his or her free will and must have made a capable decision to consent to voluntary status."[12] However, there are many situations where patients are remaining in the hospital as "voluntary patients" under the threat of being "certified". Even P.S., the subject of the recent Court of Appeal ruling necessitating these amendments, was in a situation where he was not held on a certificate of involuntary admission or renewal. Subsequently, P.S. remained in hospital, on the understanding that his physician would complete a certificate of involuntary admission if he was to try and leave. The CCB was therefore without jurisdiction to review his "stay" in the psychiatric facility despite the fact that P.S. was not able to leave, and was for all intents and purposes, detained.[13] The proposed amendments would therefore have made no difference in the case of P.S.

We submit that voluntary and informal patients are in the same situation as an involuntary patient who has been detained for over six months. These patients suffer from the same conditions of indeterminate detention which were found to violate the liberty interests of involuntary patients and drew censure from the Court of Appeal, and all without any possibility of review. The regime created by Bill 122 offers the potential for voluntary and informal patients to seek to review their conditions of detention and for the CCB to make orders to ensure that they too are given the ability to access rehabilitation or vocational programs, or provided the opportunity to transfer to a different, more suitable facility or to access the community in which they reside.

ACE recommends that *any* patient who wishes to apply to the CCB who has been in a psychiatric facility for six months be permitted to access the new review powers outlined by section 41.1(2) of Bill 122.

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[12] *Dougherty v. Stall*, [2002] OJ No 4715, 48 ETR (2d) 8 (SCJ)
[13] *PS (Re),* 2013 CanLII 62017 (ON CCB)

2. No treatment without consent or transfer ordered over patient objections

No Treatment without Consent

The *HCCA* clearly indicates that that no treatment should be administered without the consent of the patient or, if the patient is incapable of consenting to the treatment, the consent of the SDM.[14] In fact, the proposed amendments are mindful of this prohibition in indicating that no order given pursuant to section 41.1(2) should direct or require that a patient submit to treatment.[15] However, paradoxically, section 41.1(5) of Bill 122 provides that:

> … if a physician agrees to provide psychiatric or other treatment to the patient and the patient, or the patient's substitute decision-maker, consents to the treatment in accordance with the requirements of the *Health Care Consent Act*, 1996, the Board may provide that any order it makes under this section is contingent upon that agreement and consent.[16]

Capacity to consent to treatment is defined as the ability to understand the information that is relevant to making a decision about the treatment and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[17] Capacity to make a decision can fluctuate over the course of a patient's mental illness, as recognized in the *HCCA*.[18] Having an order with respect to treatment as defined in the proposed amendments, would unfairly crystallize findings, especially where it is proposed that these orders may only be made and reviewed once a year.

Further, informed consent can only be provided for treatment proposed in contemplation of a patient's present health condition. The informed consent process results in patients or SDMs obtaining information from a health care provider about the side effects, risks

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[14] *HCCA, supra,* note 1, s. 10(1)
[15] Bill 122, *supra*, note 4, s. 41.1 (4)
[16] *Ibid.,* 41.1(5)
[17] *HCCA, supra,* note 1, 4(1)
[18] *Ibid.,* 15(2)

and benefits of a proposed treatment and any alternate courses of action in order to make informed decisions about treatment made in context of the patient's condition at the time of treatment.[19] This is contextualized decision-making. Therefore, if the treatment in the order is not proposed in the context of the patient's present health condition, neither the patient nor an SDM can consent to it. Any consent to such an order would be contrary to the *HCCA.*

Section 41.1(5) is unnecessary given that where a physician proposes a treatment in the context of the patient's present health condition and the patient or the incapable patient's SDM consents to the treatment, the physician can administer the treatment without an order. The provision would only become necessary if the physician sought to hold a patient or the SDM to the treatment despite the fact that consent to the treatment was withdrawn. Such a practice would be contrary to the *HCCA.*

Where the patient is competent, the law must respect the autonomy of the patient, including their ability to subsequently refuse or withdraw consent to treatment. Where consent is being obtained from an SDM, the *HCCA* allows the health care provider proposing the treatment to make an application to the CCB where consent is refused or withdrawn by an SDM on an incapable person's behalf, if the provider believes that the SDM has not complied with the *HCCA* in making the decision with respect to treatment.[20] It is therefore our position that the granting the additional power to the CCB to order treatment is unnecessary.

ACE supports the recommendation of the MHLC in seeking that this provision be removed.

<u>No Transfer without Consent</u>

The amendments to the *MHA* seek to revise the transfer provision and include it as one of the orders which may be granted by the CCB when confirming a certificate of continuation. The proposed provision reads as follows: "Transfer the patient to another

[19] *Ibid.*, s. 11(3)
[20] *Ibid.*, s. 37

psychiatric facility if the patient does not object, **subject to subsections (10), (11) and (12)**."[21]

Subsection 10 lists considerations for transfer, including whether the transfer is in the patient's best interests or whether the transfer is likely to improve the patient's condition or well-being.[22] It is unclear from this wording whether the intent is that a patient can be transferred over their objections if the CCB finds that a transfer is in the patient's best interests or that the transfer is likely to improve the patient's condition or well- being.

ACE submits that the wording for the amended transfer position could lead to confusion and unintended consequences. The present transfer power in the *MHA* does not grant the CCB the power to transfer a patient over his or her objection. There is no indication that the government intends to make a drastic change to the *MHA* which would permit a patient to be transferred in such a manner.

Further, subsections 11 and 12, which discuss the continuation of detention in the new facility to which the patient has been transferred and the transfer of records respectively, do not seem germane to the consideration of whether or not the patient is transferred.[23] It is not logical that the transfer of the patient would be made subject to these issues.

ACE recommends that section 41.1(2)(1) read "Transfer the patient to another psychiatric facility, if the patient does not object" removing the term "subject to subsections (10), (11) and (12)." Section 41.1(10) can be altered to read, "In determining whether to order that a patient be transferred to another psychiatric facility pursuant to section 41.1(2)(1), the Board shall consider whether …"

ACE supports the MHLC's recommendation that the role of the Minister or Deputy Minister in the context of an order to transfer a patient be clarified and that timelines be set to ensure that transfers are not delayed.

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[21] Bill 122, *supra*, note 4, s. 41.1 (2)(1)
[22] *Ibid.*, s. 41.1(10)
[23] *Ibid.*, s. 41.1(11) and (12)

3. Composition of the CCB

Bill 122 proposes to include registered nurses in the extended class and physicians who are not psychiatrists as members who can take the place of psychiatrist members at hearings on certificates of involuntary admission or renewal. However, on a certificate of continuance, a psychiatrist member must still sit with a lawyer member and a member who is neither a psychiatrist nor a lawyer to have quorum to hold a hearing. ACE supports the inclusion of registered nurses in the extended class or physicians in the pool of CCB members; however, these persons must have the requisite expertise in mental health in order to preside over the hearings.

Nevertheless, it is crucial that the expertise in mental health not be mainly from experiences in a hospital or institutional setting. Frontline community workers, who have experience with patients who may have mental health issues, or patient advocates in non-governmental organizations would be excellent sources of this expertise. These members would bring a differing perspective and have expertise in the community resources. They would be of assistance in addressing some of Bill 122's proposed review powers to be provided to the CCB, such as ordering community privileges or access to vocational, interpretation or rehabilitative services.

ACE recommends that the CCB's membership include persons with patient-side experience (outside the hospital context) and supports the MHLC's recommendation that a certain percentage of the CCB's membership be persons with lived experience in the mental health system.

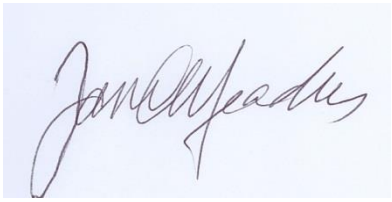
CONCLUSION

ACE supports the spirit of the changes which will be brought about the proposed amendments to the *MHA*. It is essential in a flourishing democracy that the liberty interests of those detained in psychiatric facilities are protected and that any limitations on liberty are the least restrictive options. In order to ensure that the amendments do not exclude equally vulnerable patients or force treatment on patients without consent or transfers on unwilling patients, and to ensure that the CCB has the required expertise to conduct a fulsome review of detention, ACE recommends that:

- Informal and voluntary patients who have been in a psychiatric facility for six months and wish to apply to the CCB be permitted to access the new review powers outlined by section 41.1(2);
- Section 41.1(5) be removed;
- Section 41.1(2)(1) read “Transfer the patient to another psychiatric facility, if the patient does not object” removing the term “subject to subsections (10), (11) and (12)”;
- Section 41.1(10) be altered to read, “In determining whether to order that a patient be transferred to another psychiatric facility under section 41.1(2)(1), the Board shall consider whether …”;
- All CCB members be recruited on their expertise in mental health issues, such as capacity and health care consent; and,
- The CCB’s membership include persons with patient-side experience (outside the institutional context).

Thank you for your consideration of these submissions. We welcome any questions that you may have.

SUBMITTED ON BEHALF OF THE ADVOCACY CENTRE FOR THE ELDERLY



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